

HOSPITALS AND HEALTH CLINICS

Indian Health Service

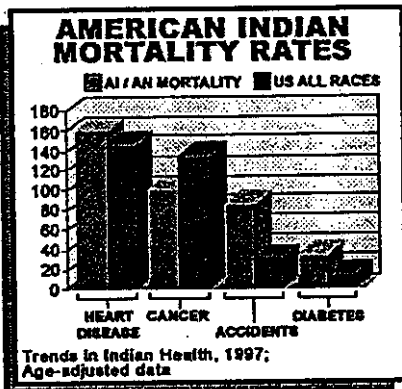
<u>Clinical Services</u>	2000	2001	2002	2002 Est.	2002 Est.
	<u>Actual</u>	<u>Appropriation</u>	<u>Estimate</u>	<u>+/-</u> 2000 Actual	<u>+/-</u> 2001 Approp.
<u>Hospitals & Health Clinics</u>					
A. Budget Authority	\$1,005,407,000	\$1,084,173,000	\$1,137,711,000	+\$132,304,000	+\$53,538,000
B. (HIV/AIDS)	(\$2,423,000)	(\$2,702,000)	(\$2,754,000)	(+\$331,000)	(\$52,000)
C. FTE	6,877	6,953	7,047	+170	+94
D. (HIV/AIDS)	(14)	(14)	(14)	(0)	(0)
E. Activity:					
Inpatient:					
# of Days	274,700	273,000	273,000	-1,700	0
Outpatient:					
# of Visits:					
Hospitals....	3,750,000	3,832,000	4,880,000	+1,130,000	+1,048,000
Free-Standing Clinic Visits	<u>3,840,000</u>	<u>3,924,500</u>	<u>5,000,000</u>	<u>+1,160,000</u>	<u>+1,075,500</u>
Total, Visits	7,590,000	7,757,000	9,880,000	+2,290,000	+2,123,500

PURPOSE AND METHOD OF OPERATION

Mission Driven Program

The Hospitals and Health Clinics budget provides funding for health care essential to American Indians and Alaska Natives (AI/AN) and critical to the IHS mission. The mission of the agency is to elevate the health status of its service population to the highest possible level and eliminate disparities in health between AI/ANs and the general U.S. population. Since there are significant disparities in the health of AI/AN, this mission is quite challenging.

This element of the budget supports a full range of clinical, preventive, and rehabilitative services and is pivotal to realizing improved health for AI/ANs. As will be described below, while the programs provide high quality services in a cost effective manner, the full range of services is not uniformly available to all Indian communities. This budget request includes targeted increases for this budget activity.



Scope of Services in Isolated Communities is Comprehensive

The Hospitals and Health Clinics budget supports essential personal health services including inpatient care, routine and emergency ambulatory care, and medical support services including laboratory, pharmacy, nutrition, health education, medical records, physical therapy, nursing, etc. These services are generally unavailable from any other sources in the communities served through IHS. In addition, the program

includes public health initiatives targeting special health conditions that disproportionately affect AI/ANS such as specialized programs for diabetes, maternal and child health, youth services, communicable diseases, including AIDS, tuberculosis, and hepatitis, and a continuing emphasis on women's and elder health and disease surveillance.

Other clinical services, e.g., dentistry and community services (e.g., public health nursing, emergency medical services, and community health representatives) along with a number of health programs operated by the tribes (e.g., the USDA nutrition program for women, infants, and children), and behavioral health services (alcohol, substance abuse, and mental health services) are often housed in the same facilities. This co-location of services in the hospital and clinic increases access and promotes a comprehensive community-oriented program that maximizes the synergistic use of human and capital resources. This also facilitates measurement of outcomes around common goals.

Achieve Quality and Customer Satisfaction

The Hospitals and Health Clinics budget provides annual operating expenses for over 500 health care facilities providing in-patient, routine and emergency ambulatory care, and support services. The IHS and tribal staff of these facilities are committed to delivering the highest quality care possible with available resource. The effect of this commitment is reflected in the continuing success in achieving and maintaining Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation of IHS and tribal-operated facilities. JCAHO, the Accreditation Association of Ambulatory Health Care (AAAHC), and the Health Care Financing Administration (HCFA) regularly and periodically conduct in-depth reviews of the quality of care provided. These accrediting bodies also review the status and safety of the facilities, adequacy and competency of staffing, and management of the service delivery components of the IHS.

These reviews are based upon the concept of continuous quality improvement in clinical programs utilizing specific performance measures to assess quality of care. The IHS and the tribes fully embrace this concept and services are provided and evaluated using the industry benchmarks for customer satisfaction. The average IHS and tribal hospital accreditation grid score has consistently been at or above the average score for all U.S. hospitals (average IHS scores are in the 90's on a scale of 0-100). The most frequently cited area for improvement is the physical plant safety and efficiency.

All 49 of the IHS funded hospitals are JCAHO accredited and 85 percent of the health centers and clinics have achieved accreditation (some are too small to qualify for accreditation). By comparison, less than 50 percent of non-IHS rural hospitals are JCAHO accredited.

Performance Measures Demonstrate Effectiveness

This review process requires that the staffs of the health facility establish performance indicators and demonstrate routine monitoring, analysis, and intervention where the desired outcome is not achieved. Accreditation of individual facilities is based on appropriately established objectives and meeting these standards. Outcome measures

monitored by clinical facilities include clinical programs effectiveness such as obstetrics and childcare, management of acute cardiac events, and emergency situation response.

Service appropriateness is measured in a variety of ways. For example, peripartum care is assessed through such measures as: live births successfully managed; neonate Apgar scores (an objective measure of the infant's health at the end of labor and delivery); maternal morbidity measures such as preventable vaginal lacerations, etc.; and the hospital course of the mother and child as measured by morbidity and treatments utilized during the hospital stay. These many measures of peripartum care can be aggregately summarized with one indicator: neonatal mortality. The neonatal mortality rate among AI/AN children in the IHS service population is in fact better than the general U.S. population by 10 percent. Effective outreach activities and accessible clinical service have resulted in a relatively low percentage of low birth weight deliveries and its associated increased infant morbidity and adverse outcomes. The IHS service population rate of low birth weight deliveries is 20 percent below the rate of low birth weight deliveries in the general U.S. population.

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The annual diabetes care audit is another example of monitoring and assessment. Designed to monitor services provided to over 80,000 diabetics, this audit reviews a wide range of performance measures including foot care, eye care, end organ status, and adequacy of blood sugar control. The various measures developed by IHS for this audit are now incorporated into the National Council on Quality Assurance/American Diabetes Association proposal for national performance benchmarks for diabetes care. IHS performance against these standards has been exemplary by achieving or exceeding the proposed goals for each element.

Recently the managed care industry and state governments have proposed and measured HMO performance against a variety of performance measures contained in the HEDIS (Health Plan Employer Data and Information Set) data set. When compared to HMO performance in the broader population, the IHS-funded programs are at the very top in most measures. For example, the HEDIS data set establishes age specific immunization rates for children served under an HMO (or other managed care plan) similar to the HHS HP 2000 goals.

A survey of Maryland HMO's (including Kaiser, Aetna and 13 other HMO's) found the average immunization rate to be 67 percent. The IHS average for the same goal was 89 percent during the same time period.

Similarly, the Maryland study also revealed that HMO's achieved screening goals for eye exams on diabetic patients at a rate of 40 percent of the target expectation. The IHS conducts eye exams on greater than 55 percent of its diabetic patients utilizing the same target goal.

Some other IHS outreach and prevention program effectiveness measures are not normally measured by private industry making head to head comparisons difficult to make. For instance, IHS funded nutrition education services

uses service provision location to assess penetration of education into the population. More than 30 percent of these activities occur in a community setting in IHS funded programs. IHS believes that these services are crucial for prevention and control yet there is no industry benchmark for comparison. Performance successes assessed through many other health indicators are documented annually in the Agency publications, Trends in Indian Health, and the Regional Differences in Indian Health. These examples indicate that clinical and prevention efforts continuously measure quality through routinely documented, collected, and analyzed data and also highlight the areas where disparities exist.

Training Crucial

This commitment to quality requires regular and specialized training to assure continued success. Thus, the Hospitals and Health Clinics budget activity supports continuing medical education for a wide variety of the health professionals employed by the IHS and tribes. This includes specialized training in quality assurance and case management as well as discipline-specific training. The FY 2001 budget provided some advanced and specialized training for nurses in intensive care unit and operating room skills, nursing management, and the upgrading of Indian individuals from licensed practical nursing to registered nursing. The budget enabled IHS to support quality assurance training through JCAHO, residency training for IHS physicians, residency training for pharmacists, and continuing education of mid-level providers (physician assistants, nurse practitioners, and pharmacy practitioners). These activities are continued in FY 2002.

Managed Care at Work

The Hospitals and Health Clinics activities are enhanced through a managed care process predicated on strategies for providing

- The highest volume of quality services within appropriation.
- And a rational plan for cost recovery and cost avoidance.

One key aspect in demonstrating the success of this approach is the increasing volume of third party recovery by IHS and tribal facilities (cost recovery). The volume of third party recovery increased by 108 percent between 1995 and 2000. The elimination of unnecessary costs through negotiated rates for purchased services and medical products has also assisted in cost avoidance efforts. To manage growing pharmaceutical costs, IHS uses limited formularies in the service sites, bulk purchasing agreements, and other cost containment approaches.

Through prudent and efficient delivery of care, the IHS provides comprehensive services described above for \$1,400 per person per year, a cost of more than 50 percent below that of health insurance for Federal employees.

The IHS provides the comprehensive services described above for \$1,400 per person per year, a cost of more than 50 percent below that of health insurance for Federal employees. (Federal employees are funded at approximately \$2,900 per person per year. See IHS LNF Report). The IHS not only manages care through its quality assurance program, but it manages costs effectively as well.

Community Oriented Primary Care Attacks Changing Disease

The IHS program continues to focus on increasing access to preventive and curative services for the underserved in Indian communities. This is ordinarily dealt with by targeting clinical, preventive, and restorative care to communities. The IHS funded programs utilize a strategy of targeted health programming based on community health status to try and provide the most useful services to the most people.

The event leading to death or morbidity appears to be acute, but the factors leading to the illness are chronic in nature.

In recent years the diseases affecting AI/ANs have changed and required a change in service focus. The AI/AN disease burden due to acute illness is decreasing while the chronic disease burden is increasing. Significant behavioral determinants often accompany chronic disease. Of particular concern are disease patterns that disrupt families and communities including accidents, suicides, homicides, family violence and chemical dependency. Prevention of these conditions requires a different set of precepts and disciplines, as they are less susceptible to traditional medical model interventions. These prevention strategies are often difficult to maintain since the impact of the programs is often distant in time and community attention to these efforts may wane in the face of more immediate concerns (such as treatment for trauma associated with family violence).

Promising new developments include community-based wellness centers, school and community based-adolescent clinics and community-based health screening services and these give energy to continued investment in such less immediately gratifying efforts. In one case, Zuni, NM, published data in *MMWR*, *Runner's World*, *Diabetes Care*, and *Public Health Reports*, suggesting that the use of the community wellness center reduced dependence on medication among diabetics and that participants required fewer medical visits than those who did not access the wellness center.

This emphasis on community-oriented primary care is particularly well suited to the unique health needs of AI/AN people. The impressive accomplishments of the IHS have resulted from the broad community approach employing public health nurses (PHNs), alcoholism workers, mental health workers, and sanitarians in partnership with the medical/clinical staff. These skills more directly address the community effects of higher unemployment, lower socioeconomic status, and the complications of poor nutrition, sanitation, and housing found in many AI/AN communities.

Maintaining progress made

The progress made utilizing this strategic approach requires maintenance and continued efforts. This budget proposes to increase funding to allow for maintenance (in the face of increased resource and supply cost, increased population, and utilization), and strategic investments to reduce the disparate disease burden among AI/AN people compared to the general U.S. population.

ACCOMPLISHMENTS

The agency made significant progress in addressing chronic diseases. The primary focus has been in treatment and prevention of diabetes. The increases provided have allowed greater access to the most sophisticated interventions available. This includes more effective pharmaceuticals, more aggressive screening for the secondary effects of diabetes, earlier intervention when complications are identified, and greater patient compliance with care regimes. A full report on the impact of the diabetes grant program was provided in January 2001 to the Congress and further details are also provided elsewhere in this document.

Additional funding was provided for podiatric services in FY2001. The funds have allowed the addition of a number of podiatrists to provide services at the community level. The most important impact of these funds however was to raise the awareness of all providers of the importance of screening, prevention, and early intervention in changes associated with diabetes. In FY 2001, IHS staff also published material documenting the effectiveness of these strategies in reducing amputations in AI/AN populations. These strategies are being actively disseminated as standards of care for prevention and treatment of diabetic complications.

During FY 2001 the agency also examined the underlying causes and risk factors contributing to the development of diabetes and heart disease. Of particular interest is a report provided to Congress exploring the scope and impact of obesity as a risk factor in the development of chronic disease. This report noted that obesity is three times more frequent among AI/AN children and this disparity persists into adult life. This high rate of obesity clearly contributes to the development of diabetes and heart disease. The report also provided information on promising interventions that may reduce the risk for chronic disease. Some are as simple as the promotion of breast-feeding in infancy and others involve wider community commitment to dietary and exercise interventions. The agency is examining means to disseminate these interventions on a wider basis. The agency has entered into a partnership with the National Heart, Blood, and Lung Institute in three communities to demonstrate the efficacy of community based interventions. These activities show promise and in FY 2001, IHS and NHLBI will explore with tribes means to disseminate these findings and programs.

Other promising partnerships with NIH entities have emerged during FY 2001. Of significance was the funding of Native American Research Centers in Health (NARCH). This program developed in partnership with the National Institute of General Medical Studies (NIGMS) will provide support for tribally controlled research centers to focus on the diseases disparately affecting American Indian and Alaska Native people. It has the added advantage of developing AI/AN researchers who will focus on the communities from which they come. This will help assure that the most scientific understanding of the impact of disease in this unique population is explored and disseminated.

In FY 2001 promising partnerships were also developed with the Centers for Disease Control and Prevention. Of particular significance in this partnership is the enhancement of a variety of public health capabilities serving AI/AN communities. For example, a strong partnership with the CDC diabetes activities is designed to assure that best practices in diabetes management are identified and disseminated using the joint resources of the

CDC Diabetes Translation and Dissemination Program and the IHS Diabetes Program. Another example is the partnership aimed at surveillance and prevention of Hepatitis C initiated in FY 2001. This critical effort is needed since the rates of Hepatitis C appear to be higher in AI/AN populations and it is a preventable disease. Another effort supported by the collaborative activities between CDC and IHS is support for the developing tribal epidemiology centers. This public health capacity is vital to informing tribal leadership and other policy makers about the specifics of health needs and efficacious interventions. It has increased the tribal capacity to exercise the public health functions of government.

The agency has also taken great strides in addressing pharmacy issues during FY 2001. This includes analysis of the factors leading to the steep rise in pharmaceutical costs and the implementation of some interventions to assume greater control of these costs. The interventions initiated or enhanced in FY 2001 to control costs include greater use of bulk purchasing methods, increased use of a limited but more efficacious formulary, and education of providers about specific pharmacoeconomic strategies. This effort was enhanced by the provision of resources for expansion of the IHS pharmacy residency activities. The residency programs now operate in 11 communities and stimulate innovative thinking about the control of pharmaceutical costs and less expensive, but more effective approaches to patient care. Of particular significance is the increase in pharmacist care for such programs as anti-coagulation and cancer chemotherapy management. This provides more in-depth care (under physician supervision) that capitalizes on the unique skills of pharmacists with specialized technical training in these areas.

Emergency services also utilized an increase to improve programs at the community level during FY 2001. The Congress provided funds that assisted the EMS programs in a variety of communities to assure the stability of staffing and the maintenance of vital equipment. It also stimulated new analysis to be completed in FY 2001 that will define the state of the art efforts that exist in rural America and how these might be disseminated. Many community ambulance services in rural America are struggling to survive (both Indian and non-Indian) and the IHS is looking for creative ways to create partnerships that will strengthen local EMS efforts. IHS has entered into a partnership with the Health Resources and Services Administration (HRSA) to jointly examine these issues.

Lastly, the agency has explored and resolved a number of policy issues with the Health Care Financing Administration. These issues included such matters as eligibility and co-payment concerns in the State Children's Health Insurance Program (SCHIP). These efforts were aimed at assuring the greatest possible utilization of resources available to eligible AI/AN patients for services.

Performance Measures

The following performance indicators are included in the IHS FY 2002 Annual Performance Plan. These indicators are sentinel indicators representative of some of the more significant health problems affecting AI/AN. At the FY 2002 funding level, IHS would be able to achieve the following:

Indicator 1: During FY 2002, continue tracking (i.e., data collection and analyses) Area age-specific diabetes prevalence rates to identify trends in the age-specific prevalence of diabetes

(as a surrogate marker for diabetes incidence) for the AI/AN population.

- Indicator 2: During FY 2002, continue the trend of improved glycemic control in the proportion of I/T/U clients with diagnosed diabetes.
- Indicator 3: During FY 2002, continue the trend of improved blood pressure control in the proportion of I/T/U clients with diagnosed diabetes who have achieved blood pressure control standards.
- Indicator 4: During FY 2002, continue the trend of increasing the proportion of I/T/U clients with diagnosed diabetes assessed for dyslipidemia (i. e., LDL cholesterol).
- Indicator 5: During FY 2002, continue the trend of increasing the proportion of I/T/U clients with diagnosed diabetes assessed for nephropathy.
- Indicator 6: During FY 2002, increase the proportion of women 18 and older that has had a Pap screen in the previous year by 2 percent over the FY 2001 level.
- Indicator 7: During FY 2002, increase the proportion of the AI/AN female population over 40 years of age that has received screening mammography in the previous two years by 2 percent over the FY 2001 level.
- Indicator 8: During FY 2002, increase the proportion of AI/AN children served by IHS receiving a minimum of four well-child visits by 27 months of age by 2 percent over the FY 2001 level.
- Indicator 10: During FY 2002, increase the proportion of I/T/U prenatal clinics utilizing a recognized screening and case management protocol(s) for pregnant substance abusing women by 5 percent over the FY 2001 level.
- Indicator 20: During FY 2002, maintain 100 percent accreditation of all IHS hospitals and outpatient clinics.
- Indicator 21: During FY 2002, establish baseline health care consumer satisfaction levels for all IHS.
- Indicator 23: During FY 2002, increase the proportion of AI/AN children who have completed all recommended immunizations for ages 0-27 months (as recommended by Advisory Committee on Immunization Practices) by 1 percent over the FY 2001 level.
- Indicator 24: During FY 2002, increase pneumococcal and influenza vaccination levels among adult diabetics and adults aged 65 years and older by 1 percent over the FY 2000 level.
- Indicator 26: During FY 2002, reduce injury-related hospitalizations for AI/AN people by 2 percent over the FY 2001 level.
- Indicator 29: During FY 2002, maintain ongoing body mass index (BMI) assessments in AI/AN children 3-5 years old and/or 8-10

years old, for both intervention pilot sites and non-intervention comparison sites and evaluate community acceptance and participation in program interventions.

Following are the funding levels for the last 5 fiscal years:

<u>Year</u>	<u>Funding</u>	<u>FTE</u>
1997	\$891,824,000	7,991
1998	\$906,801,000	8,020
1999	\$949,140,000	8,067
2000	\$1,005,407,000	6,877
2001	\$1,084,173,000	6,953 Enacted

RATIONALE FOR BUDGET REQUEST

Total Request -- The request of \$1,137,711,000 and 7,047 FTE is an increase of \$53,538,000 and 94 FTE over the FY 2001 enacted level of \$1,084,173,000 and 6,953 FTE. The increase includes the following:

Built-in Increases (pay increases) - +\$34,366,000

The provision of funds for pay increases for Federal and tribal employees are crucial if the system is to retain its employees. The retention of providers in rural health delivery organizations is critical. Since the salaries of health workers in urban environments is steadily rising, the out migration of employees to more lucrative urban and suburban jobs is threatening to leave rural health programs with very few over-worked providers and support staff. This reality has led to a vacancy rate of approximately 30 percent in dental staff and greater than 25 percent in pharmacy staff, and high vacancy rates in nursing and medical staff. Provision of appropriate and competitive salaries is critical to the operation of the system. The tribal and Federal programs are experiencing similar vacancy rates in critical positions.

Phasing-In of Staff for New Facilities - +\$7,172,000 and 94 FTE

The request of \$7,172,000 and 94 FTE provides for the phasing-in of staff and related costs for new facilities. The staffing of new facilities also contributes to the recruitment and retention of medical staff and promotes self-determination activities. The following table displays the requested increase.

<u>Facilities:</u>	<u>Dollars</u>	<u>FTE</u>
Ft. Defiance, AZ Hospital	\$1,079,000	14
Parker, AZ Health Center	6,093,000	80
Total	\$7,172,000	94

Requests for additional amounts for staffing at Ft. Defiance, AZ and Winnebago, NE hospitals are under development.

Indian Health Care Improvement Funds - \$8,000,000

The Indian Health Care Improvement Fund resources are used to address the variable needs of AI/AN communities. Because of historical appropriation and allocation events, there are inequalities in the availability of resources among AI/AN communities. The Congress recognizes these

disparities among communities and the disparity between the health of American Indians and Alaska Natives and the general population and authorized the funding of resources to address these differences.

Appropriations were provided in FY 2000 FY 2001. The agency distributed the FY 2000 funds on a non-recurring basis pending the completion of a major analysis on the relative level of funding available (level of Need study) to tribes requested by Congress. This study utilized standard actuarial methods to compare the availability of health resources for American Indians and Alaska Natives to the benefits available to Federal employees under the Federal Employee Health Benefits Program. This analysis revealed a more equitable approach to allocate the Indian Health Care Improvement Fund. The use of the Level of Need study information for the purposes of allocation of the Fund is currently under consultation with the tribes, but it is anticipated that its use in some form will be the basis for allocation of the Fund during FY 2001.

In FY 2000, the Fund was used to augment the available services provided through the hospitals and clinics. In general it was used to support non-recurring costs through purchased care (contract health care). It was allocated based on an assessment of need that was recognized as interim.

Information Technology - +\$4,000,000: See Tab on page 137.